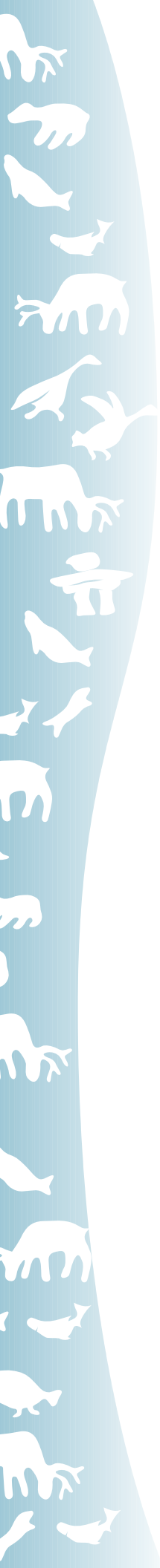
TABLE OF CONTENTS



WHAT IS HOME AND COMMUNITY CARE?

The term “home and community care” often evokes different perceptions of types and levels of services. The following section provides an overview of home and community care services as they relate to the First Nations and Inuit Home and Community Care (FNIHCC) Program.

Home and Community Care Overview

The following are basic components of Home and Community Care:

- provides services to people mainly in the home;
- provides services based on needs identified through a client assessment;
- designed to help people keep their independence in their own home and allow them to be close to their loved ones as long as possible;
- provides care in a holistic manner that looks at a person’s physical, social, spiritual and emotional needs, recognizing that each person is different and unique; and
- supports and improves the care provided by the family and community but does not replace it.

Services of Home and Community Care

The services that make up Home and Community Care include:

Client Assessment

This is carried out through:

- speaking with the client and the client’s family
- speaking with the client’s doctor and other care providers
- review of client’s health history
- physical check up

Case Management

This is the step after assessment to ensure that the plan for care is right and is provided by the right caregiver at the right time.

Home Care Nursing

- nursing care that is provided in a home or community setting
- includes teaching client and client's family about self care
- may include supervision of workers providing personal care services

Personal Care

- assistance with activities such as bathing, foot care, and dressing

Home Support

- help with light housekeeping, laundry, and meal preparation

In-Home Respite Services

- care for the client while the family, who usually cares for client, has a rest and it is not safe for the client to be left alone

Beneficiaries of Home and Community Care Services

Persons of any age who have an assessed need who:

- have been discharged from a hospital;
- have an illness or disease requiring follow up care;
- are unable to live alone while waiting for care in a long term care facility;
- have a disability requiring assistance to live on their own;
- need nursing care in the home; and/or
- choose to live at home instead of in a long-term care facility as long as it is safe, affordable and services are available.

Others who may benefit from Home and Community Care include family and friends who need support to continue to care for people in the home.

Referral Process

Clients may refer themselves or they may be referred by family members, friends, doctors, neighbours, or hospitals.

Service Providers

Home and Community Care services are provided mainly by registered nurses, licensed practical nurses and certified home health aides/personal care workers at the community level. Home health aides/personal care workers should be supported and supervised by registered nurses.

ABOUT THE FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE (FNIHCC) PROGRAM

Program Background

In 1998, a Continuing Care Working Group was formed and included representation from Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), Health Canada's First Nations and Inuit Health Branch (FNIHB), and the Department of Indian Affairs and Northern Development (DIAND). This group laid the foundation for the First Nations and Inuit Home and Community Care (FNIHCC) Program and the first phase the working group addressed was home care. The FNIHCC Program was announced in the federal budget of February 1999.

The FNIHCC Program provides basic Home and Community Care services designed to be comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians and which respond to the unique health and social needs of First Nations and Inuit communities. The Program is a coordinated system of home and community based health-related services that enable people with disabilities, persistent or acute illnesses and the elderly to receive the care they need in their home communities.

The planning and implementation of this initiative is carried out in partnership between the Federal Government (via FNIHB), AFN and ITK. The FNIHCC Program is intended to be built upon and/or enhance other existing federal programs such as Adult Care (In-home component) funded by Indian and Northern Affairs Canada (formerly DIAND) and the Home Nursing component of the Building Healthy Communities program.

A total of $152M was made available for the first three years of the program with an ongoing funding level of $90M per annum at the end of the three-year developmental period. The funding for the first three years of the FNIHCC Program is as follows:

Program Year	Fiscal Year	Funding
1	1999/2000	$17M
2	2000/2001	$45M
3	2001/2002	$90M

Funding for Years 2 and 3 included significant resources to begin to address capital and training requirements for the program. Criteria on accessing these resources were prepared, approved by the National Steering Committee and forwarded to FNIHB Regions as well as First Nations and Inuit communities.

Program Objectives

The primary objectives of the FNIHCC Program are:

- to build the capacity within First Nations and Inuit to develop and deliver comprehensive, culturally sensitive, accessible and effective home care services;
- to assist First Nations and Inuit living with persistent and acute illness in maintaining optimum health, well-being and independence in their homes and communities;
- to facilitate the effective use of home care resources through a structured, culturally-defined and sensitive assessment process to determine service needs of clients and the development of a care plan;
- to ensure that all clients with an assessed need for home care services have access to a comprehensive array of services within the community, where possible;
- to assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize community support services where available and appropriate in the care of clients; and
- to build the capacity within First Nations and Inuit to deliver home care services through training and evolving technology and information systems to monitor care and services and to develop measurable objectives and indicators.

Eligibility

The eligible recipients for this program are:

- First Nations and Inuit of any age;
- who live on an Inuit settlement, First Nations reserve or First Nation community North of 60;
- who have undergone a formal assessment of their continuing care service needs and have been assessed to require one or more of the essential services; and
- who have access to services that can be provided with reasonable safety to the client and caregiver, within established standards, policies and regulation for service practice.

Program Elements

Essential Service Elements

Essential service elements provide the foundation upon which future program enhancements can build. They include:

- a structured client assessment process that includes on-going reassessments and determines client needs and service allocation. Assessment is a structured dynamic process of continuous information gathering and knowledgeable judgements that attach meaning to the information being gathered. Assessment and reassessment processes can involve the client, family and other care givers and /or service providers;
- a managed care process that incorporates case management, referrals and service linkages to existing services provided both on and off reserve/settlement;
- home care nursing services that include direct service delivery as well as supervision and teaching of personnel providing personal care services;

- the delivery of home support personal care services that are determined by the community needs assessment plan and that do not duplicate, but enhance existing Department of Indian Affairs and Northern Development (DIAND) adult care services (e.g. bathing, grooming, dressing, transferring, care of bed-bound clients including turning, back rubs and routine skin care, etc.);
- provision of in-home respite care;
- established linkages with other professional and social services that may include coordinated assessment processes, referral protocols and service links with hospital service providers, physicians, nurse practitioners, advanced practice nurses, respite and therapeutic services;
- provision of and access to specialized medical equipment, supplies and specialized pharmaceuticals to provide home and community care;
- the capacity to manage the delivery of the home and community care program that is delivered in a safe and effective manner, if existing community infrastructure exists; and
- a system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities.

Supportive Service Elements

The essential service elements of the Home and Community Care Program are expected to be developed initially in each First Nation or Inuit community. The Home and Community Care Program may expand to include supportive service elements based on community needs and priorities, existing infrastructure and availability of resources.

Supportive elements that may be provided within a continuum of home and community care might include, but are not limited, to:

- facilitation and linkages for rehabilitation and therapy services;
- respite care;
- adult day care;

- meal programs;
- mental health home-based services for long-term psychiatric clients and clients experiencing mental or emotional illness. These services might include traditional counselling and healing services, and medication monitoring;
- support services to maintain independent living, which may include assistance with special transportation needs, grocery shopping, accessing specialized services and interpretative services;
- home-based palliative care;
- social services directly related to continuing care issues; and
- specialized health promotion, wellness and fitness.

The FNIHCC Program:

- **will not** fund the construction and/or delivery of long term care institutional services; and
- **will not** duplicate funding for existing on reserve adult care services.

Program Status

A tracking tool was developed for the First Nations and Inuit Home and Community Care program whereby the progress in planning activities is reported on a Regional level and submitted to Headquarters on a quarterly basis.

The following is a summary of the level of activity as of the end of the 2001/02 fiscal year:

- 667 of 697 eligible communities have been funded for Program developmental activities;
- 87% have completed a program needs assessment;
- 80% have submitted service delivery plans;
- 51% of the eligible communities have access to services reaching more than 63% of First Nations and Inuit people (i.e. over 282,000 First Nations and Inuit have services in their community); and
- Among eligible Inuit communities, 34 of 54 are in service delivery.

FNIHCC Program: Canada-wide Figures

Population	441,634
Average Population per Community	634
Number of Communities Eligible for Funding	697
Number of Communities Funded	669
% of Needs Assessments Completed	87%
% of Communities with Submitted Plans	80%
% of Communities in Planning Implementation	73%
% of Communities with Access to Service Delivery	51%

2001/02

National Steering Committee

Background

A National Steering Committee comprised of members from the partnership was established in the 1999/00 fiscal year and continued to be actively involved in providing direction and feedback into the developmental activities during 2000/01 and 2001/02. The National Steering Committee held its first meeting in May 1999 and has met on a quarterly basis to provide National direction on program implementation.

Needs-Based Strategy

The National Steering Committee approved the funding framework for the FNIHCC prior to the Treasury Board Submission. The intent of the funding framework was to provide a starting point to the development of a true needs-based funding formula. It was recognized that there was an insufficient amount of existing data to use in a funding framework that would truly reflect the Home and Community Care needs of First Nations and Inuit. The National Steering Committee approved a "Needs-Based Strategy" that would collect data to be used to support a sustainable program.

The following are the strategic elements, tasks and activities developed to implement the Needs-Based Strategy:

- establish/adopt and maintain a National First Nations and Inuit Population Database collected in a consistent manner;
- evaluate care proxies employed in the funding formula and analysis of utilization of services by predetermined indicators;
- determine the cost of service delivery by service types;
- establish an information base to determine second and third level program support services requirements and associated costs; and
- establish evidence/collect data about issues that will affect program sustainability

National Workplan: 2001/02

The First Nations and Inuit Home and Community Care Program is built upon partnership and collaboration. In order to demonstrate a national partnership process, each year a National Workplan is prepared collaboratively between FNIHB Headquarters, the Assembly of First Nations (AFN) and the Inuit Tapiriit Kanatami (ITK). This Workplan is then presented to the National Steering Committee for approval.

The following is the Workplan that was developed and approved for the 2001-2002 fiscal year.

- to be responsive to identified Regional and Territorial needs for the development and implementation of the FNIHCC Program;
- to enhance linkages with other programs such as NIHB, TeleHealth, Diabetes and Nursing;
- to participate in the development of strategies to enhance the development of continuing care for Inuit and First Nations;
- to meet program accountability requirements;
- to access program expertise to support fourth level activities; and
- to continue to support a collaborative process in the development and implementation of the FNIHCC Program.

Program Phases

There are four key phases of the FNIHCC Program.

1. Needs Assessment
2. Service delivery plan
3. Policies and Procedures/Preparation to Deliver
4. Full Service Delivery

Funding Rollout

In 2000/01, a change was made to the funding process to address concerns that some communities were stalled in the needs assessment phase, thereby negating the ability of people to receive services in communities. While a basic principle of the program was ‘community-paced’, the National Steering Committee modified the formula for rollout

of funding during 2000/01 so that funding to communities would coincide with the stage of planning and implementation. This was to encourage communities to reach the service delivery phase. Although, the 2001/02 fiscal year was the final developmental period identified in the Treasury Board submission, given the 'community-based, community-paced' nature of the planning activities, not all First Nations and Inuit communities were in service delivery at the end of the fiscal year.

The modification to the funding formula was controversial as it attempted to balance the capacity and pace within communities with the home care requirements of the population requiring services. During 2000/01 and 2001/02, communities moved through the various phases through the support of First Nations and Inuit organizations, Tribal Councils, PTOs, Health Canada, health care workers, and other stakeholders.

Peer Review Process

While all of the community plans were vetted through the National Team for review, comment, and approval, it was identified that a thorough review of 600 proposals by the National Team alone was insufficient and that a more effective strategy would be to have plans also peer reviewed within each Region. In 2000/01, a peer review process was developed in collaboration with Regions. Most Regions set up working groups to address this task. One challenge many faced was that communities did not want to comment on another community's plans. To address this, the National Team coordinated training sessions on how to develop and implement an effective peer review process and each Region sent a representative to attend. As part of the training package, tools were provided to take back to the Regions.

Training Plans

Training plans were driven by the Regions. Plans were coordinated by the Regions with communities, Tribal Councils and First Nations and Inuit organizations and submitted to the National Steering Committee for approval. Criteria were developed to ensure the training was certified and divided relatively equally among communities so as wide a reach and as much capacity was developed as possible.

According to 2001/02 tracking data, across Canada approximately 1,200 training positions were earmarked through program plans for

personal care workers. This reflects a doubling of the number of planned personal care workers compared with figures prior to the FNIHCC Program. Prior to the FNIHCC Program there were 15 home care LPN positions identified across the country. Training plans indicated that this would grow ten-fold to 150. For Registered Nurses, the increase was from 124 existing position to 402 according to training plans.

A training handbook was produced as part of a planning resource kit to assist Regions and communities in developing their training plans.

Capital Plans

During this two-year period, Regional capital plans were developed, approved and implemented. Headquarters identified a specialist in this area to work with Regions and communities. It was key that the capital process was in concert with other capital activities to ensure efficiency and effectiveness.

A capital planning handbook was also produced and distributed to Regions and communities.

Communications

As with any program of this scope and magnitude, effective communications was an ongoing challenge during these two years. The National Team worked with Regions, First Nations and Inuit partners, and communities in establishing appropriate communications methods and channels.

Community Visits

National members conducted site visits across the country to meet with program staff and obtain status updates.

Regional Presentations

The National Steering Committee wanted to hear from Regions directly. Several Regions made presentations to the NSC during this period to provide updates on Regional and community-specific successes and challenges.

Resources Developed/Distributed

A planning resource kit was developed and distributed to Regions and communities.

The following handbooks were part of this resource kit, designed to assist communities in all aspects of planning and implementation:

- Getting Started
- Needs Assessment
- Service Delivery Plan
- Capital Plan
- Training Plan
- Preparation Activities
- Program Service Delivery

In addition, information was also provided on liability issues and Home and Community Care Standards, Templates, and Procedures were developed and distributed. Comprehensive information and resources pertaining to the Home and Community Care Program was made available on the Health Canada website.

National and Regional Meetings and Presentations

In an effort to maintain ongoing communication, FNIHCC National Team members provided updates and presentations at various National and Regional meetings. In addition to meetings with various First Nations and Inuit organizations and communities and with FNIHB Regions, presentations were made at the following workshops and conferences in 2000/01:

Meeting/Conference	Location	Date
Regional Nursing Officers/ Regional Nurse Educators	Quebec City	April 2000
Atlantic Steering Committee	Moncton	April 2000
Saskatchewan Region Management Committee	Regina	April 2000
Ontario Region and First Nations	Toronto	May 2000
National meeting of ADI, FNIHCC, and TeleHealth	Ottawa	July 2000
Aboriginal Reference Group on Disability Issues	Calgary	Sept. 2000
Yukon FNIHCC Steering Committee	Whitehorse	October/November 2000
Atlantic Health Conference	Halifax	November 2000
BC Health Conference	Vancouver	November 2000
National Home Care Conference	Calgary	December 2000
Southern Ontario First Nations	London	February 2001
AFN National Health Conference	Ottawa	February 2001
Northern Ontario First Nations	Thunder Bay	March 2001

Program Linkages

One of the items identified in the National Workplan for 2001/02 was to enhance linkages with other programs. Following is a synopsis of a few of these linkages.

Non-Insured Health Benefits (NIHB)

One of the essential elements for the FNIHCC Program is 'access to medical supplies and equipment'. In the first year of the Program, the National Steering Committee directed the development of a strategy that

would ensure not only linkages with NIHB, but would also ensure timely access to medical supplies and equipment to clients receiving home and community care services.

A working group was established with Regional and National representation from both programs and from both organizations. A draft strategy was tabled with the National Steering Committees from both programs. A major recommendation provided by this working group was to allow home care nurses to authorize the purchase and payment by NIHB on a limited number of high utilization items. These include incontinent supplies, dressings, and diabetic supplies. Processes and procedures were initialized to work toward implementation of this policy revision.

Human Resources Development Canada (HRDC)

HRDC has funded a number of labour sector studies. Several years ago, a Home Care labour sector study was initiated. Coordinated by a very large National Steering Committee it includes a management committee comprised of five organizations in order to access and manage the funding for this study. First Nations and Inuit were invited to participate as members of the National Steering Committee. As well, there was a literature review carried out on home care issues as they relate to Aboriginal communities. This literature review was incorporated into the final report of Phase 1 of the sector study. A call for proposals had been issued for additional research in First Nations and Inuit communities as it relates to staffing, recruitment and other issues. However, due to funding shortfalls at HRDC, it now appears that this component of the research will not proceed. The National Steering Committee for the FNIHCC Program met with the HRDC to look for opportunities for overlap and to obtain HRDC reporting, particularly in the area of disabilities.

Indian and Northern Affairs Canada (INAC, formerly DIAND)

The current First Nations and Inuit Home and Community Care Program was initiated primarily as a result of work that was carried out by a Joint FNIHB/DIAND (now INAC)/AFN/ITK Working Group in 1998. The initial plan was the development of a comprehensive Continuing Care Framework with Home and Community Care identified as Phase 1. Since the announcement of this program, much of the activities within First Nations and Inuit communities have been geared in implementing the FNIHCC Program. There has been relatively little work on the continuation of the Continuing Care Framework development, particularly as it pertains to Institutional and/or other Adult Care programs.

Many First Nations continued to identify major gaps in their ability to deliver a range of continuing care programs. Combined with the lack of mandate for Institutional care within INAC or FNIHB, efforts were made to bring a group of program experts together to begin the discussions on the development of the institutional component of the Continuing Care Strategy. The framework is anticipated to be completed in 2002/03.

It was always the intent of both INAC and FNIHB that there would be a continuation of the work in the development of the Continuing Care Framework. INAC had arranged for a number of background research documents to be completed. There have also been strong lobbying efforts carried out by First Nations in the lifting of the moratorium. As a result, a National meeting was coordinated by INAC and held in Winnipeg in November 2000. Many Regional Home and Community Care Coordinators (both First Nations and FNIHB) attended this meeting along with representatives from the INAC Regions and Social Development technicians. The meeting was used to develop a better understanding of issues and gaps in respect to continuing care. Inuit sat as observers at this meeting.

As First Nations and Inuit began their needs assessment and program planning activities, the lack of access to culturally appropriate supportive housing and institutional care facilities was identified as a major gap in the continuum of care. Since the mid 1980s, DIAND (now INAC) has held a moratorium on the funding for the construction and operation of institutional care facilities on reserve.

During these two years, communications and information sharing was a cornerstone for collaboration between the two programs and included INAC identifying one individual specifically to work with the FNIHCC Program team. Collaborations were conducted on both a National and Regional level that addressed policy and program implementation issues.

In February 2001, an ITK Health Committee Meeting was held in Ottawa. A need for Inuit Continuing care was identified and the Health Committee directed the ITK Health Department to develop a proposal for submission to FNIHB to conduct research in that area.

Palliative/End of Life Care

Several years ago, a Senate Committee chaired by Senator Sharon Carstairs held a series of hearings across the country to obtain feedback on the palliative/end of care needs of Canadians. As a result, the federal

government established a Palliative Care/End of Life Secretariat within Health Canada and Senator Carstairs was appointed Minister with Special Responsibilities for Palliative Care.

One of the critical tasks for the Palliative/End of Life Secretariat was the development of a National Action Plan on Palliative/End of Life Care. A National meeting was held in Winnipeg in March 2002. Approximately one hundred and fifty (150) people with special knowledge and expertise in palliative/end of life care were invited to participate at this meeting. Provisions were also made to ensure the participation of First Nations and Inuit.

There were two activities carried out by the FNIHCC Program to support the development of the National Action Plan on Palliative/End of Life Care. They were:

1. Recruitment of meeting participants

   Regions and First Nations/Inuit organizations were asked to identify people who had experience in Palliative/End of Life Care or who had special knowledge of the issues. As a result, approximately 30 people were nominated. However, the Palliative/End of Life Secretariat had the responsibility of making the final selection of meeting participants. The result was that approximately fifteen people participated, including two Elders who brought wisdom and knowledge not only to the Aboriginal participants but also to the experts and medical professionals in attendance. The final workshop report clearly demonstrates the input provided by First Nations and Inuit.

2. Funding the National Aboriginal Health Organization (NAHO) to develop a discussion paper on End of Life/Palliative Care for Aboriginal Peoples

   A serious lack of available data existed on the needs of aboriginal people in the area of palliative/end of life care. This discussion paper was presented at the National Workshop and was used by the Aboriginal participants at the meeting in addressing some of the issues that were raised. Inuit Tapiriit Kanatami (ITK) produced a Palliative Care discussion paper outlining the Inuit characteristics and planning issues that need to be integrated in the National Action Plan for End-of-Life-care.

Office of Nursing Services

Preliminary discussions were held during this period with the Office of Nursing Services at the First Nations and Inuit Health Branch to investigate ways of integrating activities and communications.

The Office of Nursing Services is responsible for:

- recruitment, management and retention of community health nurses in First Nations and Inuit Health Branch;
- support to FNIHB Regions in the delivery of nursing services;
- analysis of trends and strategic leadership on nursing services;
- nursing practice, standards and competency; and
- nursing education and staff development.

Generic Standards and Policies

One requirement for the implementation of the FNIHCC Program is for communities to demonstrate there are program standards and policies in place. Due to the different program models developed and the various jurisdictional issues, no attempt was made to impose a set of standards and policies on First Nations and Inuit. However, it was recognized that the development of standards is a cumbersome process and that many communities did not have the capacity to carry out this activity.

For this reason, in 2000/01 St. Elizabeth's Health care, a private non-profit health organization in Ontario, was contracted to develop generic standards and policies for the use, adaptation, and modification by First Nations and Inuit. The National working group on Standards, Policies, Scope of Practice and Training guided these developmental activities.

Health Transition Fund: Evaluation of Home Care Pilot Projects

In 1997, Health Canada established a Health Transition Fund (HTF) to support innovative approaches that responded to emerging health issues within the reforms taking place within the Canadian health systems. FNIHB submitted a proposal to fund Home Care pilot projects.

Phase 1 created five Home and Community Care projects, which were used to assess the feasibility of implementing the home care framework that had been developed by a National working group. These pilot projects were completed in the 1999-2000 fiscal year.

Prior to the completion of the Round One HTF pilot projects, FNIHB again partnered with First Nations and Inuit and submitted a proposal for another series of Home and Community Care pilot projects focussing on diabetes. The purpose of these projects was to:

- develop and test modes of home and community care based diabetes care, support and education;
- establish linkages and coordination of services; and
- validate the home care framework and Aboriginal Diabetes Initiative.

In 2000/2001, a final evaluation was conducted on these pilot projects. The major findings of the evaluation identified that:

- involving community members in the planning process is key to ensuring that services are responsive to community needs; and
- effective community-based home care diabetes programs are based on community needs while services are client-centred.

Program Evaluation and Accountability

A Results-Based Management and Accountability Framework (RMAF) forms the evaluation framework for the FNIHCC Program. This framework describes the integrated approach by which the FNIHCC Program will measure, manage and report on results throughout its life cycle. It also contains an evaluation plan, which includes information such as what, when, and how to evaluate.

An Evaluation Working Group was established with representation from communities, First Nations and Inuit organizations, and Health Canada. One of the primary tasks of the working group during this period was the development and publication of the RMAF for the FNIHCC Program.

The RMAF describes the roles and responsibilities for Health Canada and First Nations and Inuit communities in the implementation and delivery of the FNIHCC Program. It presents a clear and logical program design that links program resources to expected outcomes through a chain of activities, outputs, and expected outcomes. It lays out an appropriate performance management approach that includes ongoing performance measurement, an evaluation strategy, adequate reporting on achievements and accountability for results.

The RMAF represents an understanding between all partners in program delivery as to what they aim to achieve, how they will work together to achieve it and how they will measure and report on outcomes. The RMAF is a tool for better program management and continuous learning.

Among the strategic actions included were:

- a multi-year evaluation plan that includes: three separate studies to examine development- and implementation-related questions; development of specific indicators and outcomes and the collection of specific data elements to measure against these indicators; and
- development of resources to share with communities to facilitate capacity-building and engagement in these activities, e.g. a menu of community-based, Tribal Council and Regional evaluation questions are being developed for the consideration of communities, Tribal Councils and Regions.

The full document is available in the FNIHB publication *Home and Community Care Program Results-Based Management and Accountability Framework.*

Health Information System (HIS)

An expert group comprised primarily of community home care service providers developed user requirements for the home care module of the First Nations and Inuit Health Information System (FNIHIS). Approval was given by e-Health in 2001/02.

Tracking Tool

During 2000/01, the National Team released a tracking tool to the Regions to assist in the data collection and reporting requirements for the program. Presentations were made to assist Regions in implementing the tracking tool.

Data collected at the Regional level through the tool included the following:

- Number of communities eligible for funding
- Number of communities funded
- Population
- % of Needs Assessments completed
- % of Communities with Submitted Plans
- % of Communities in Planning Implementation
- % of Communities with Access to Service Delivery
- % of Population with Access to Service Delivery
- Overview of Program Affiliation/Delivery Model
- Overview of Training
- Human Resource Profile
- Linkages Developed between FNIHCC and other Programs

Highlights from tracking data for 2001/02 have been included in the regional summaries.

REGIONAL OVERVIEW

The following sections provide summaries of Regional activities and structure during the 2000/01 and 2001/02 fiscal years. As the summaries illustrate, each Region faces a unique environment in which the planning and implementation of the Program must occur. Factors include size and number of communities, existing capacity and infrastructure, Regional partnerships, Regional staffing, and community needs, among others.

For example, British Columbia has over 200 communities, the largest number of any Region. Yet these communities tend to be small and many are isolated. In Saskatchewan, an existing First Nations Home Care Working Group had been established for over a decade, providing a unique foundation for building services and capacity. While the Atlantic Region may be comparatively smaller than most Regions in terms of total First Nations and Inuit population, efforts must be coordinated across four provinces and with a number of First Nations and Inuit organizations servicing these varied communities. The territories face unique challenges, not the least of which is extremely isolated communities, many of which have acute capacity challenges due, in part, to the isolation and the high costs associated.

While planning and implementation of the program varied from Region to Region, there were some common activities and challenges faced.

Communications

Regional coordinating teams utilized a number of methods to communicate with communities, Tribal Councils, PTOs, First Nations and Inuit partners, National Team, and other stakeholders.

With Other Regions

Although meetings were held during this two-year period with representatives of the National and Regional teams, in 2001/02 the Regional program coordinators spearheaded their own working groups. The objective of these working groups was to address mutual challenges and share learning from the program. Working groups addressed various issues including nursing, data collection, isolation, and evaluation.

With National Team

In addition to ad hoc meetings and teleconferences, a prime communication tool for Regions was utilization of the tracking tool to report on program status.

With Partners

Partnerships were both established and strengthened across Regions during this period. Meetings were held, information shared, and working groups and sub-committees were struck. These partnerships were on a number of levels and varied from Region to Region but generally included:

- First Nations and Inuit organizations on Local, Regional, Provincial/Territorial, and National levels.
- Education and Training Institutions
- Provincial and Regional Health Departments and Authorities
- Government departments and agencies (e.g. INAC, other Health Canada programs, etc.)

With Communities

While time and travel resources were limited, Regional and National staff travelled to communities when possible to conduct both formal and informal presentations and meetings with program staff. Telephone, fax, mail, and email contact with program staff were common across Regions during this period to address community issues and communicate information.

One key challenge has been having people recognize “what is home care”. Unlike INAC’s Adult Care (in-home component), home care must be based on an assessed need. Ongoing education was required about the types of services provided through the FNIHCC Program.

In addition to ongoing reporting requirements, some communities provided monthly or ad hoc reports over and above the required reports to update the coordinating teams.

Training

Training plans were developed at the Regional level, typically in consultation with communities, Tribal Councils, PTOs, and other First Nations and Inuit partners. These plans were then submitted to the National Team for approval.

The needs within each Region varied as did the training requirements and training sources. Regions worked with educational and training institutions to come up with unique curriculum and delivery solutions to help meet the goals of the program, while working within a finite funding level that provided for training funding for the 2000/01 and 2001/02 fiscal years.

Capital Projects

As with training plans, capital plans were developed by the Regions in consultation with communities and based, in part, on community needs assessments. Regions developed working groups or capital committees to address this opportunity. Capital projects were key during this period as a significant portion of program funding for 2000/01 and 2001/02 was earmarked toward capital projects. Again, as with training, Regional capital plans were submitted to the National Team for review, comment, and approval.

In most Regions, capital projects focused on the building or development of home and community care space and on purchasing basic medial supplies and equipment. In some Regions, the focus was more on office and storage space or accommodations for health care workers, while in other Regions more emphasis was placed on supplies and equipment. Although the capital funding provided much needed support for infrastructure development to support the program in communities, Regions report acute needs for further capital funding to develop and sustain the work being done in communities. After full service delivery, Regions assume responsibility for ongoing capital needs.

While Regions were able to provide some additional storage, office space, supplies and equipment to support the program, they were also challenged to address all of the capital requirements using the two years of funding. Some Regions utilized budget variances to augment capital budgets.

The Regions

There are eight Regions for the program. They include:

- Pacific
- Alberta
- Saskatchewan
- Manitoba
- Ontario
- Quebec
- Atlantic
- Northern Secretariat (Territories)

Following is a synopsis of each Region for the years 2000/01 and 2001/02.

Pacific

Pacific Region Profile

Population	63,416
Average (Mean) Population per Community	311
Number of Communities Eligible for Funding	204
Number of Communities Funded	191
% of Needs Assessments Completed	72%
% of Communities with Submitted Plans	69%
% of Communities in Planning Implementation	58%
% of Communities with Access to Service Delivery	40%

2001/02

The Pacific Region (British Columbia) is home to 204 communities, the highest number for any Region. Most communities are small and many are isolated. With the average community size at 311, the Region's communities tend to be significantly smaller compared with other Regions.

Structure

A partnership was established with the First Nations Chiefs= Health Committee (CHC) for the FNIHCC Program. Communities/collectivities were assisted with their needs assessments and service delivery plans, plans were peer reviewed, and a Regional joint steering committee was struck.

Two home care nurse advisors were hired. One worked out of the CHC's offices and the other from FNIHB's Regional office. As well, funding provided for one home and community care regional coordinator and an administrative support position. Recruiting was also underway for a second home care nurse advisor at FNIHB that would serve the southern communities. The CHC hired a second person to work on the FNIHCC Program, a development advisor who assisted communities with the development of needs assessments and service delivery plans along with the two home care nurse advisors. Working groups, such as the NIHB Working Group, were struck.

Program Overview: 2000/01 and 2001/02

The coordinating team helped increase awareness of the Program in communities and increase the number of communities who completed needs assessments and service delivery plans. The result was more communities in full service delivery. With a greater awareness of community services and with the access of funding for home care programming locally, more First Nations people across British Columbia had access to Home and Community Care services. As staffing on the BC Home and Community Care team increased, there was an increase in the number of band contacts made, a challenge with 204 bands in the province.

The combination of many small, isolated communities presents a unique challenge to build capacity among First Nations communities to assess, plan, implement, maintain, and monitor a Home and Community Care program. Despite these challenges, almost three-quarters of communities completed needs assessments by the end of 2001/02 in British Columbia. In addition, approximately 40% of communities were in the service delivery phase. This represented 51% of the First Nations population in the province, indicative of the fact that larger communities tended to reach service delivery phases sooner than smaller communities. By the end of 2001/02, over 93% of communities had accessed Home and Community Care funding.

Training

The increasing number of communities accessing FNIHCC Program funding during this period resulted in increased capacity in First Nations communities in British Columbia. Coinciding with this was increased training and work opportunities for First Nations people because of this program funding. Communities identified a variety of training opportunities for home support workers and home care nurses and a variety of partnerships and training models emerged.

According to program tracking data, in BC the number of personal care workers was fewer than 10 prior to the FNIHCC Program. Training plans indicated that this was scheduled to increase to 267 through FNIHCC Program funding. Both formal and informal types of training were provided.

Formal training provided included training for certified home support workers, (personal care aides) and, Home Care Nursing training, and training for Peer Review Committee members.

- Bands/collectivities worked together to provide home and community care as well as training for home support workers.
- In several cases, larger communities helped smaller communities by offering space for training when available. The FNIHCC team also prepared and reviewed scope of work for personal care aides and disseminated to communities.
- In some communities “laddering programs” were developed whereby students trained to be home support workers could then go on to become LPNs and then RNs.
- Program representatives from both the CHC and FNIHB took the Home Care Nursing Training from the University College of Cariboo in Kamloops. The training took place over six weekends during an eight-week period and provided the program staff more knowledge about the more technical aspects of a home care program and how it rolls out in a provincial system. The college modified the curriculum to make it specific to First Nations communities providing both theoretical and practical perspectives. The two-week practicum at a regional (provincial) health authority proved very beneficial to the program representatives.

Informal training provided to communities included initial training sessions to introduce the program in several locations in BC and presentations provided to individual communities/collectivities in their own communities.

Partnerships

Following are examples of partnerships fostered during the first two years of the program.

First Nations

- A strong partnership formed with the First Nations Chiefs' Health Committee (CHC), particularly through the CHC Home Care Nurse Advisor.
- BC Aboriginal Network on Disabilities Society (BCANDS) was contracted to mail out several hundred copies of the home care video to First Nations bands across Canada.
- Three First Nations bands/collectivities were involved in the development of a home care video that was distributed Canada-wide.

Provincial

- There was increased awareness of the Province's "Continuing Care" program and opportunities for linkages with the FNIHCC Program at the community level.

Educational & Training Institutions

- A partnership emerged with the University College of the Cariboo in Kamloops for Home Care nursing training specific to First Nations environments.
- First Nations educational groups developed and conducted training of home support workers.

Program Linkages

Across the country, Regions linked with other federal agencies and programs, where possible. In BC, this included:

INAC (DIAND)

- Work was done on how to link the INAC Adult in-home care program with FNIHCC at the community level.

HRDC

- A presentation was made to the ARDA=s of BC regarding training requirements for Home Support Workers to raise awareness of the program and the need for an increase in financial support for these students.

Within Health Canada

- Linkages were made with the Corporate Services Branch to assist with the building of space for FNIHCC Programs in First Nations communities throughout BC.
- Discussions were held with NIHB program representatives, in part, to determine equipment and supplies clients would be eligible for under the NIHB program. Discussions also took place regarding NIHB partnering with Veterans Affairs Canada (VAC) to share an equipment depot providing new or refurbished equipment to home and community care clients. Equipment for VAC clients is relatively extensive and this unique solution helps to maximize usage and cost-effectiveness through reuse following refurbishing.

Resources Developed/Distributed

Following are some of the resources developed or distributed within BC during this period.

- A home care video was developed in partnership with three First Nations communities/collectivities. The videos were ultimately distributed nationally to all bands in Canada by BCANDS.
- A service delivery plan tool kit for communities was shared with all communities who were working on completing service delivery plans in 2001/02. It included “best practices” examples of actual communities who had completed plans, using these communities’ permission. The took kit was in print format and included a summary of community needs

assessment, program goals and objectives, foundation to address changing needs, Capital plan, linkages, referral process between agencies, outline of resource needs, job description qualifications, orientation plan, team relationships, appropriate liability insurance, implementation strategy and timelines, evaluation (3 components), fiscal responsibilities, program quality assurance, accountability to community members, budget with sample budget, training plans, partnerships, information and data collection.

- Presentation materials (i.e. overhead transparencies) were reviewed, revised, and updated on an ongoing basis for usage with communities and other federal government agencies.
- Three manuals were developed and distributed to communities within the province and made available to other Regions. They included:
    - home support worker policy and procedure manual;
    - home care nursing policy and procedure manual; and
    - orientation manual for home care nurses and their supervisors.

Alberta

Alberta Region Profile

Population	58,305
Average (Mean) Population per Community	1,005
Number of Communities Eligible for Funding	58
Number of Communities Funded	57
% of Needs Assessments Completed	97%
% of Communities with Submitted Plans	97%
% of Communities in Planning Implementation	97%
% of Communities with Access to Service Delivery	95%

2001/02

With a First Nations population of just over 58,000 in 58 communities, Alberta's on-reserve population approaches its BC neighbour, yet Alberta has approximately one-quarter of the number of communities. The Blood Tribe, located in the southern part of the province, is geographically the largest reserve in Canada and has a population approaching 10,000.

Structure

The peer review process began in January 1999 with representation from each of the province's three treaty areas (Treaty 6, Treaty 7, and Treaty 8). The process also included representation from INAC.

At a Regional level, the FNIHCC Regional Coordinator was the only dedicated resource to the program within Alberta during this period.

Program Overview: 2000/01 and 2001/02

By the end of 2000/01, 38 implementation plans were received, representing 44 First Nations. They included 31 independent communities and 7 Tribal Councils. Community Workplan requirements included the requisite itemized budget for expenses such as salaries, benefits, o&m, respite, palliative, rehab, liability insurance, etc. Capital and training plans were also developed.

Many communities were in service delivery by the end of 2000/01 and almost all were in service delivery by the end of 2001/02, with most home care programs run directly by each band.

As communities in Alberta were moving through the phases of the program relatively quickly, Regional Workplans and other relevant information were shared with other Regions as applicable.

Most communities had a home care nurse and some were able to hire personal care aides and Licensed Practical Nurses (LPNs). Communities with larger populations tended to have more capacity to carry out more supportive services such as palliative care and meals on wheels. By the end of 2001/02 there were 38 Band home care nurses and 5 FNIHB home care nurses. Health directors became increasingly aware of the home care program and the corresponding needs of the community.

Communities had to adjust to steep learning curves, including the overall scope of home care and the referral and assessment processes involved. Some of the smaller communities, for example, faced challenges in hiring and managing home care nurses while still trying to learn the role and scope of home care nursing. Community health workers and home care workers worked closely together. In some smaller communities, the needs of the population were such that they did not require direct services during this period but utilized more supportive services. In other cases, communities might have had many palliative care clients, requiring an entirely different scope of services and care.

Training

Initially, much of the community training plans focused on personal care aide training as many were using community health representatives for home care. According to program tracking data, there were 134 personal care workers in Alberta communities prior to the program. Training plans indicate that this figure would increase to 404 through program funding. The number of LPNs would increase from 13 to 84 positions and the number of RNs from 42 to 118.

- Twenty community training plans were approved and training programs included Personal Care Aides, LPNs, Rehab Aides, Wound Care, & Palliative Care.
- Thirty-three individuals at the community level were provided with repair and maintenance training to provide basic home repairs for those individuals lacking family support or financial capacity.
- RNs and LPNs in communities completed basic or advanced foot care training. Personal care aides also attended a foot care information session for unregulated workers.

- Eight home care nurses completed the Case Management Program through Grant MacEwan College in Edmonton.
- In 2001/02 the Personal Care Aide program was bridged to an LPN program. Some communities trained rehab aides and/or offered wound care and palliative care courses.

Partnerships

Following are examples of partnerships fostered during the first two years of the program.

First Nations

- Each of the province's three treaty areas (Treaty 6, Treaty 7, and Treaty 8) was part of the planning and implementation process.

Provincial

- Through the Capital Health Authority (CHA), existing policies and procedures were adapted for HCC needs. The CHA was also accessed for recent research information on wound care guidelines based on evidence-based practice.

Educational & Training Institutions

- Meetings were held in 2000/01 with training institutions to increase awareness of the FNIHCC Program and many adapted training programs to the communities. For example, an upgrading program for personal care aides and LPNs was developed to meet traditional literacy and educational requirements. Some of this training took place in communities and some at regional colleges. Funding included instructors, books, and supplies but did not provide for allowances or travel expenses.

Program Linkages

Across the country, Regions linked with other federal agencies and programs, where possible. In Alberta, this included:

INAC

- Fourteen Alberta communities integrated with the INAC Adult Care Program, including moving financial and human resources to home care. This was challenging in many respects, including the fact that family members were no longer paid for taking care of family members whereas they had been paid in the past. Associated policies were developed in these communities.

HRDC

- Communities accessed HRDC and social services for other sources of funding to compliment services provided through FNIHCC funding.

Within Health Canada

- Many communities brought the ADI and FNIHCC Programs together at the community level. Communities would submit programming through ADI funding and many were able to leverage human resources through these linkages.
- Work ensued that involved the Drug Distribution Centre and Medical Supplies and Equipment Working Group to devise a specific form for home care services separate from community health. The Working Group also addressed funding of associated supplies and equipment.

Resources Developed/Distributed

A home care project nurse was contracted in November 2000 to review and revise an outdated Home Care Manual. Information from the National manual was adapted to the Alberta Region and the manuals were distributed in March 2002 to all home care programs and zone nursing managers.

Saskatchewan

Saskatchewan Region Profile

Population	52,168
Average Population per Community	629
Number of Communities Eligible for Funding	83
Number of Communities Funded	82
% of Needs Assessments Completed	99%
% of Communities with Submitted Plans	99%
% of Communities in Planning Implementation	99%
% of Communities with Access to Service Delivery	99%

2001/02

By the end of 2001/02, all of the eligible communities had completed the needs assessment process, submitted plans, and conducted planning implementation. In fact, all but one community was in service delivery.

Structure

Prior to the introduction of the FNIHCC Program, Saskatchewan had an established Saskatchewan First Nations Home Care Working Group, formed in the early 1990s. Created through the Federation of Saskatchewan Indian Nations (FSIN), this group was comprised primarily of First Nation employed home care service providers and health directors. This working group had already developed a framework and infrastructure for First Nations home care in the province and played a critical role in supporting the implementation of the FNIHCC Program.

Saskatchewan has two communities with populations over 2,000 and a small number in the 1,000 – 2,000 range. Some smaller communities chose to contract with the provincial health district authority in lieu of aligning with other First Nations communities. In 2000/01, with the agreement of First Nations, a portion of the planning funding was used to establish coordinator positions for the program. These included:

- One regional coordinator at FSIN; and
- Three area coordinators; one each for the North, Central, and Southern areas.

With these four positions staffed through FNIHCC funding for both years, as well as the Regional Coordinator position at FNIHB, there was significant capacity in place to assist communities in the needs assessments, service delivery planning, and peer review processes of the program.

Program Overview: 2000/01 and 2001/02

The coordinating team, in conjunction with the Home Care Working Group, focused on supporting community-driven needs assessments, which almost all communities completed by the end of 2000/01. Because of these collective efforts, there was significant awareness among communities about the FNIHCC Program by the end of 2000/01.

While there was existing programming and capacity in the province, a number of smaller communities did not have resources or alliances. The result was that the program enhanced services in some communities and provided new services in other communities where none previously existed. The foundation was developed during these two years for these new and enhanced services.

Through the training and capital plans, communities were able to begin building capacity to address home care services.

In 2001/02 one of the primary accomplishments in the Region was the completion of all service delivery plans, including the peer review process. This was accomplished through a combination of sessions and workshops, cooperation, and support. Because First Nations communities did not want to lose any funding, the plans were put together in a relatively short period in order to meet the funding requirements.

First Nations in Saskatchewan led the development over the two years at the community and Tribal Council level and through organizations such as FSIN and the Northern Inter-Tribal Health Authority. This latter group has contributed to the high amount of capacity that exists in northern Saskatchewan. Saskatchewan has a relatively high amount of health transfer, which has developed First Nations capacity. Some communities in Saskatchewan have been running their own health programs from over ten years. The Battleford Tribal Council (BTC) home care team in central Saskatchewan has been involved in diabetes research with a Toronto hospital. Peter Ballantyne Cree Nation includes several communities in the northeast. In 2001/02, they implemented an electronic health

information system database for their home care program. Part of the program includes nurses using palm pilots in the field to record information.

Training

The Saskatchewan team developed a Regional training plan in 2000 and began offering training to communities on creating service delivery plans. A peer review team was established and training followed on conducting peer reviews for service delivery planning and for developing associated criteria for reviews. In developing the criteria, the National criteria was used as a base model and adapted to Saskatchewan-specific needs.

The training of Home Health Aides (HHA) was a primary focus. The goal was to have at least one HHA trained in each community by the end of 2001/02. Training sessions were held in ten locations across the province, which were geographically structured in such a way that most communities had relatively easy access. By the end of 2001/02, the original goal of training at least one HHA in each community had been reached and actually surpassed in many communities. According to program tracking data, the number of personal care workers in communities was 131 prior to the program. Training plans indicate this figure would increase to 289 through program funding. The number of registered nurses for home care would increase from 31 to 100 according to training plans.

Case management/assessment training was also coordinated for Home and Community Care professionals. The Saskatchewan coordinating team liaised with a number of educational institutions, employers, and students to develop and providing training programs as per the approved training plans.

Partnerships

Following are examples of partnerships fostered during the first two years of the program.

First Nations

- The Federation of Saskatchewan Indian Nations (FSIN) was involved closely with all aspects of program planning and implementation during this period.

Educational & Training Institutions

- Partnerships were developed with educational institutions such as the Saskatchewan Indian Institute of Technologies (SIIT) and the Saskatchewan Institute of Applied Science and Technology (SIAST) to establish culturally appropriate training programs.

Provincial

- Relationships were established with some of the Regional provincial health authorities and with the Provincial Home Care departments.

Program Linkages

Across the country, Regions linked with other federal agencies and programs, where possible. In Saskatchewan, this included:

INAC

- Some preliminary work was done in conjunction with INAC on the continuing care framework.

Within Health Canada

- The team participated in National and Regional discussions on how the NIHB policy affects the FNIHCC Program. Communications were also held ongoing with ADI and community health nursing programs to seek ways of leveraging the programs.

Resources Developed/Distribute

In Saskatchewan, a solid existing infrastructure minimized the need for development of new materials. Existing policy manuals, standards and charts were distributed, as required, and the National office's planning resource binder was distributed to all communities.

Manitoba

Manitoba Region Profile

Population	67,556
Average Population per Community	1,090
Number of Communities Eligible for Funding	62
Number of Communities Funded	61
% of Needs Assessments Completed	100%
% of Communities with Submitted Plans	97%
% of Communities in Planning Implementation	82%
% of Communities with Access to Service Delivery	55%

2001/02

Manitoba is home to the second largest First Nation on-reserve population in Canada, with only the province of Ontario having a greater on-reserve population. By the end of 2001/02, all of the community needs assessments had been completed and most communities had submitted service delivery plans for the peer review process. Just over one-half of these communities were in full service delivery, representing approximately two-thirds of the on-reserve population in the province.

In terms of size, six communities have a population less than 500, 21 communities with a population between 500 and 1000, and 25 communities with a population greater than 1000. In terms of types of communities Manitoba Region has 1 Type 1, 23 Type 2, 10 Type 3, and 24 Type 4 communities.

Structure

In February 2000, a Nurse in Charge from Community Health was hired as assistant regional coordinator for the FNIHCC Program. In addition to this position and the existing FNIHCC regional coordinator, a full-time administrative support position was also hired in June 2000.

There were seven full time nurse coordinator positions funded at the Tribal Council levels (Tribal Council home and community coordinators). For example, the Keewatin Tribal Council nurse coordinator worked with the 11 affiliated communities. The Four Arrows Regional Health Authority

has 4 communities serviced by the coordinator. Of the 62 First Nations communities in the province, 51 communities are affiliated with one of the seven Tribal Councils, with the remaining 11 communities independent. Regional staff serviced the independent communities.

Program Overview: 2000/01 and 2001/02

As mandated by the Chiefs' Health Committee with the Assembly of Manitoba Chiefs, a Planning and Implementation Committee for the program was established with quarterly meetings held.

Representation included Tribal Councils, independent communities and Regional coordinators within the province.

There was a significant amount of planning in 1999/00, with needs assessments a key focus of 2000/01. Training for the peer review process and the establishment of a peer review committee was also carried out in 2000/01. The peer review process included representation from Tribal Councils, Independent First Nations, First Nations members, and FNIHB. A booklet was developed that included information on roles, terms of references, goals and objectives, assessment criteria, checklist, and appeal process.

Three workshops were held on service delivery planning, one each in the south, west, and north. Numerous health forums were attended and presentations were made across the province to communities about the Home and Community Care program. A key component of the service delivery plans was to incorporate the INAC adult care programming already in place. Communities were required to demonstrate how the HCC program would adapt to their communities INAC services.

In 2001/02, additional workshops were held across the Region. For example, a workshop on standards and policies was conducted by St. Elizabeth - one each in the north, south and west regions of the province. Program staff also attended and conducted a variety of presentations and workshops both within and outside the Region.

Having the seven Regional coordinators, as well as the FNIHB Regional coordinating team, developed a significant amount of capacity to assist communities in all aspects of the program including training and capital planning and implementation, nursing services, and recruitment and retention of services.

Training

Based on community needs assessments, the focus of training for 2000/01 was to train health care aides. Over 300 health care aides were trained and capacity correspondingly increased. Training efforts were enhanced through the access of other funders such as HRDC, although the training exceeded the preliminary budget estimate. Much of the training took place within the communities with some trainees having to fly into Regional centres to attend. According to program tracking data, the number of personal care workers (health care aides) was 73 prior to the program. Training plans indicate that this figure would increase to 398 through program funding.

In addition to health care aides, LPN training programs were developed in the different Regions of the province. In the north, for example, funding provided for LPN training with 31 individuals during this period. According to tracking data, there were no LPNs or RNs for home care in communities prior to the FNIHCC Program. Training plans indicate that these numbers would increase to 18 and 85 respectively through funding.

Program coordinators attended case management symposiums held at the University of Manitoba. Program representatives also attended the Palliative Care conference and Assembly of Manitoba Chiefs' Social Development conference. The latter focused on capacity building within First Nations communities for employment and training to help at the community level to access different sources of funds available through different agencies.

The Yellowquill College is a First Nation college and training institute based in Winnipeg. The college developed a Home and Community Care Management Program tailored to the needs of communities in such areas as management, finance, and data analysis.

Training was also provided to community representatives in the area of contribution agreements, an area identified by communities as one that required better understanding.

Partnerships

Following are examples of partnerships fostered during the first two years of the program.

St. Elizabeth Health Care (Ontario)

- Provided training on policies and procedures based on expertise in home care

Kahnawake First Nation

- Provided peer review training and orientation to facilitate First Nations involvement in peer review process

VON

- Provided client assessment processes and care planning

Program Linkages

Across the country, Regions linked with other federal agencies and programs, where possible. In Manitoba, this included:

Within Health Canada

- Integration with INAC at the Regional and Local level was initiated, as applicable, to maximize the provision of services efficiently. Linkages were also strengthened with the Aboriginal Diabetes Initiative (ADI) to communicate program information and resources and to explore Regional and Local opportunities for collaboration.

Resources Developed/Distributed

A sub-working group was struck among the Home and Community Care Coordinators in the Region to develop Program and Clinical Policies and Procedures to coincide with the Standards templates that St. Elizabeth had provided. Driven by Tribal Councils, policies and procedures manuals were developed for professionals, para professionals, as well as the development of a clinical procedures manual and programs policies manuals. A consultant coordinated the project, resulting in four binders of manuals for communities.

The Peer Review Process Guidebook was developed in conjunction with Kahnawake (Quebec)

The Data Tracking Tool was utilized to meet National reporting requirements. Communities submit both electronic and manual data.

Ontario

Ontario Region Profile

Population	77,879
Average Population per Community	628
Number of Communities Eligible for Funding	124
Number of Communities Funded	117
% of Needs Assessments Completed	82%
% of Communities with Submitted Plans	63%
% of Communities in Planning Implementation	46%
% of Communities with Access to Service Delivery	11%

2001/02

Ontario Region is home to the largest population of First Nations persons in Canada and the second largest number of communities, after British Columbia.

Structure

In Ontario, FNIHB entered into an agreement with the Chiefs of Ontario. The Chiefs of Ontario, in turn, contracted to the various Provincial/Territorial Organizations. The PTOs include:

- Association of Iroquois and Allied Indians
- Grand Council Treaty #3
- Independent First Nations
- Nishnawbe-Aski Nation (NAN)
- Union of Ontario Indians

In the fall of 2000, NAN, Grand Council Treaty #3, and 15 additional First Nations elected to work directly with FNIHB. The partnership consisted of a Program Manager with the Chiefs of Ontario assisting 38 First Nations, a Program Manager with FNIHB and Grand Council Treaty #3 assisting 51 First Nations, and a Program Manager with NAN assisting 35 First Nations.

Ontario PTOs

Association of Iroquois and Allied Indians (AIAI)

- Represents eight nations of status Indians in Ontario, with a collective membership of approximately 16,000

Independent First Nations

- Includes twelve nations in the province

Nishnawbe Aski Nation (NAN)

- Evolved out of Grand Council Treaty #9, which was established in 1973 as the Regional organization representing the interests of 49 First Nations in Northern Ontario who are signatories to Treaty No. 9 and Treaty No. 5 (in Ontario). In 1982, the name changed to Nishnawbe Aski Nation. The population is estimated at approximately 25,000

Grand Council Treaty #3

- Represents 28 nations in the NW part of the province

Union of Ontario Indians

- Represents 43 nations in southern Ontario Region with a population estimated at approximately 20,000

Program Overview: 2000/01 and 2001/02

During 2000/01, agreements were set up and peer review training sessions were held across the province. More than two-thirds of communities in Ontario are small, with a mix of communities going through Tribal Councils or running programs independently. The pace of program planning and implementation varied in each community throughout the province.

In 2001/02, efforts continued on working through the various phases of the FNIHCC implementation with communities working at their own pace. By year-end, most communities had completed a needs assessment and had submitted plans. Larger communities, such as the Mohawk Bay of Quinte near Belleville and the Algonquins of Golden Lake, tended to move through the process quicker than smaller communities did. In fact, although 11% of communities were at service delivery phase by the end of 2001/02 this represented almost 34% of the on-reserve population in Ontario.

While larger communities with greater capacity were more apt to move through the process quicker, some small communities moved quickly. With a nurse in place for the program to coordinate the northern regions, this part of the province tended to move more quickly than the southern areas.

During these two years, more and more agencies throughout the province began hearing about the Program and made inquiries on behalf of their clients. In some areas, nurses were contracted and undertook the responsibility of supervising personal support workers. In Ontario, Provincial funding was utilized by communities to augment the FNIHCC funding allocation. The combination helped to lay the foundation for obtaining essential and supportive elements. Some communities were hesitant to sharing provincial funding figures for fear of losing federal funding dollars through the FNIHCC Program.

Through the planning process and associated funding for planning, communities were able to identify gaps in capacity for training, capital, and home care services. A budget variance during this period enabled more money to go towards required training and medical supplies and equipment to support the program efforts.

First Nations coordinators met frequently to discuss issues and brainstorm challenges. Workshops were conducted across the province to discuss the program and associated options and parameters.

Training

In 2001/02, the Northern Training Plan was submitted and received approval for 80% of funds. The Southern Training Plan was also submitted and received the remaining 20% of funds.

Some of the training that took place in the Ontario Region during this period included:

- skills development training for health directors;
- training personal support workers across the province; and
- foot care and dementia courses for nurses

According to program tracking data, the number of personal support workers in communities prior to the program was 167. Training plans indicate this figure would increase to 257 through program funding. The number of LPNs for home care would increase from zero to 10 and the number of home care RNs would increase from 4 to 40.

Partnerships

Following are examples of partnerships fostered during the first two years of the program.

First Nations

- The FNIHCC Program was planned and implemented in close consultation with the Chiefs of Ontario and the five PTOs, which include the Association of Iroquois and Allied Indians, First Nations of Treaty 3, Independent First Nations, Nishnawbe-Aski Nation (NAN) and the Union of Ontario Indians.

Education and Training

- Area coordinators worked with community colleges and organizations such as the Ontario Community Support Association and the Red Cross to develop training programs. These programs included training within some communities, at Regional colleges, or online training. The Ministry of Health and Long Term Care and FNIHB combined funding to increase training funds so that additional homemakers could be trained as personal support workers.

Provincial

- The Ontario Ministry of Health and Long Term Care did have some funding for home care on reserve and opportunities for linking were sought. For example, this funding provided some resources for homemaker services (cleaning, etc.) and discussions were held to look at upgrading skills to become personal support workers.
- Linkages were made with the provincial nursing program in Ontario and meetings were held to share information.
- The Province also coordinates 43 Community Care Access Centres (CCACs) across Ontario. While not First Nations-specific, communities can access the centres when applicable.

The CCACs provide a simplified service access point and are responsible for:

- determining eligibility for, and buying on behalf of consumers highest quality best priced visiting professional and homemaker services provided at home and in publicly-funded schools;
- determining eligibility for, and authorizing all admissions all long-term care facilities (nursing homes and homes for the aged);
- service planning and case management for each client; and
- providing information on and referral to all other long-term care services, including volunteer-based community services.

Program Linkages

Across the country, Regions linked with other federal agencies and programs, where possible. In Ontario, this included working with INAC, specifically with respect to the Department's Adult Care Program (in-home component).

Resources Developed/Distributed

Resources distributed included the following publications:

- Ontario Community Support Association
- Managing Risk
- Evaluation Handbook
- Becoming a Personal Support Worker
- Standards and Indicators for Personal Support and Homemaking Services
- Provincial Standards and Guidelines for Case Management
- FNIHCC Program Policy and Procedures Manual Template
- College of Nurses of Ontario Compendium of Standards of Practice for Nurses in Ontario

Some First Nations requested and received the Ontario Region Nursing Policy and Practice Manual, which is geared to Community Health Nurses Tuberculosis Manual. Information was also established on the Chiefs of Ontario website and updated monthly.

Quebec

Quebec Region Profile

Population	53,525
Average Population per Community	1,029
Number of Communities Eligible for Funding	52
Number of Communities Funded	51
% of Needs Assessments Completed	98%
% of Communities with Submitted Plans	98%
% of Communities in Planning Implementation	98%
% of Communities with Access to Service Delivery	98%

2001/02

In the Quebec Region, First Nations communities account for 85% of the Region's First Nations and Inuit population. The 38 First Nations communities represent 10 First Nations. The largest community is Kahnawake, near Montreal, which has a population of over 7,000 on the reserve itself.

Approximately 15% of the population served are Inuit in Inuit communities in the Nunavik Region. Within the fourteen Inuit communities, four have populations over 1,000 with the others as small as 125 people.

Structure

An integral part of the FNIHCC Program in Quebec is ongoing collaboration with the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and Nunavik Regional Board of Health and Social Services (NRBHSS). These two organizations play vital roles in the planning, implementation, and monitoring of the program.

The Inuit communities are linked with each other through the NRBHSS. With the exception of the nine Cree communities, the other First Nations communities operate the program independently.

Committees were struck early in the process to establish funding distribution processes to communities. Approximately half of the communities in the province are considered small and isolated.

Program staff held daily communications with partners and communities. In addition to a regional coordinator at FNIHB, there was also a contribution officer and part time nurse in 2000/01. In 2001/02, a home care nurse specialist was hired and an administrative support position was filled.

At FNQLHSSC, a home care technician position worked closely with FNIHB and provided support to communities throughout the process.

About Nunavik

The Region of Nunavik lies north of the 55th parallel in the province of Quebec. Nearly 8,000 Inuit call Nunavik home and live in 14 communities. Kuujjuaq is the Regional administrative centre with a population of approximately 1,500 residents.

With a lack of roads connecting the communities, the primary method of transportation between them and the south is via air and marine vessels.

Source: www.tapirisat.ca

About the FNQLHSSC

The FNQLHSSC is governed by a Board of Directors elected by the General Assembly. The Board of Directors is vested with all the responsibilities granted to in by the General Assembly of First Nations of Quebec and Labrador. The Board of Directors is accountable to the Chiefs of Assembly of First Nations of Quebec and Labrador and to the General Assembly.

The mission of the FNQLHSSC is to:
Improve the physical, mental, emotional, and spiritual wellbeing of First Nation and Inuit individuals, families and communities in respect of their local autonomy and culture. By helping the communities that with to initiate, develop and promote comprehensive health and social program and services as designed by First Nation and Inuit organizations recognized by our First Nations and Inuit.

Source: www.csssnpql.com

About the NRBHSS

The Nunavik Regional Board of Health and Social Services is responsible for the administration and delivery of health and social services to residents of the Nunavik Region.

Program Overview: 2000/01 and 2001/02

By the end of 2001/02, almost all communities in Quebec had undergone needs assessments, planning and were in service delivery. Annual meetings with community representatives began early in the program.

Service delivery plans were peer reviewed and evaluated by committee, with representatives visiting some communities to discuss the plans and areas of potential enhancement. By the end of August 2001, all plans were approved.

While one community was in full service delivery by the end of 2000/01, by the end of the following year five communities were in full service delivery. The remaining communities had approved plans and were in the process of implementation, working towards full service delivery.

Training

In Quebec, as in most other Regions, the training emphasis was on training home support workers, with less emphasis on training for nurses. In terms of number of positions funded by the program, tracking data shows that the number of personal care workers in the province was 431 prior to the program. Training plans indicate that this figure would increase to 488 through program funding. For home care LPNs, the figure would increase from 1 to 13 in the province and the number of RNs for home care would increase from 20 to 57.

This was a challenge for the Region's communities, as the standard of training in Quebec requires 960 hours of training for home support workers. In most other Regions, this time is in some cases a third of the time required in Quebec. Not only do these additional hours impact training funds but it is also more difficult to have people outside the community for such a long period of time, particularly when the program funding does not provide for replacement funding for people who leave for training. Training programs are often required for English

and French because of the mix of language usage among communities. Despite these challenges, at least one person in each community received training as a home support worker. In Nunavik Region, ninety people received training within the 14 communities and 30 Inuit received home care support worker certification.

In 2001/02, a two-day training session was held in Quebec City to teach workers how to use equipments provided such as glucometers, hydraulic lift for patients, and how to get assistance for technical support. Health directors, nurses, and home care workers also received computer training to assist them in their programs and documentation.

Partnerships

In Quebec, the primary partnerships developed during the two years were with the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and Nunavik Regional Board of Health and Social Services (NRBHSS).

Program Linkages

Across the country, Regions linked with other federal agencies and programs, where possible. In Quebec, one of the primary linkages was with INAC. The two organizations worked closely together on projects, including the development of common reporting mechanisms for communities.

Resources Developed/Distributed

In 2001/02, with the assistance of a consultant, the Quebec Region created a spreadsheet to be used as a tool for communities to report data on the program. The spreadsheet was so helpful it was adapted to become a National reporting template.

Atlantic

Atlantic Region Profile

Population	24,707
Average Population per Community	618
Number of Communities Eligible for Funding	40
Number of Communities Funded	38
% of Needs Assessments Completed	95%
% of Communities with Submitted Plans	83%
% of Communities in Planning Implementation	80%
% of Communities with Access to Service Delivery	45%

2001/02

While the Atlantic Region is comparatively smaller than most Regions in terms of total First Nations and Inuit population, the Region covers four provinces with many of the communities small and isolated. Half of the communities in the Region have populations under 500. Among the remainder, eight have more than 1,000 people and twelve with populations between 500 and 1000.

Province Communities	# of First Nations Communities	# of Inuit Communities	# of Innu
Prince Edward Island	2		
New Brunswick	16		
Nova Scotia	13		
Newfoundland and Labrador	1	5	2

About The Labrador Inuit and Innu Communities

The Inuit are the descendants of the Thule people who migrated to Labrador from the Canadian arctic 700 to 800 years ago. The primary Inuit settlements are Nain, Hopedale, Postville, Makkovik and Rigolet on the north coast of Labrador, but Inuit people are also found in a number of other Labrador communities. They are represented by the Labrador Inuit Association

The Innu, formerly known as the Naskapi-Montagnais, are descended from Algonkian-speaking hunter-gatherers who were one of two Aboriginal peoples inhabiting Labrador at the time of European arrival. The major Innu communities in Labrador are Sheshatshiu and Utshimassit (Davis Inlet), with respective populations of approximately 1,000 and 500. The word "Innu" means "human being" and the Innu language is called "Innu-aimun." Today there are over 16,000 Innu who live in eleven communities in Québec and two in Labrador.

Source: www.heritage.nf.ca/aboriginal/

Structure

A steering committee for the program was struck early in the process with representatives from First Nations organizations. Community information sessions were held throughout the Region to create awareness of the program. The Mi'kmaq Maliseet Health Board, for example, played an integral role in planning and communications.

Two coordinators were hired and employed by a First Nations organization. One coordinator covered New Brunswick and Prince Edward Island and the other for Nova Scotia and part of Newfoundland and Labrador. Regional coordination initially was the responsibility of the Regional Chief Nursing Officer until the FNIHCC regional coordinator was hired at FNIHB in late 2001.

Program Overview: 2000/01 and 2001/02

As money flowed to communities, they conducted needs assessments that included training, capital needs, and community home care needs. Following needs assessments, each community moved on to develop policies, programs, and procedures. While larger communities had the capacity to carry out this part of the program, smaller communities typically had significantly less capacity. In retrospect, a Regional policy and procedure that could be modified and adapted by the communities

could have helped communities and improved the process. Despite challenges, by the end of 2001/02 80% of communities had completed the planning implementation stage and almost half were in service delivery.

Except for the Regional coordination funding, most program funding for the Region went directly to the communities, the main exception being the Inuit and Innu communities. For these seven communities, the funding flowed through the Labrador Inuit Health Commission.

As communities moved through the process, program workers increased their knowledge and began establishing policies and procedures and then moving into service delivery to enable people to begin to access services. Larger communities tended to move through to this phase faster than smaller communities did. One New Brunswick community, Eell River Bar First Nation, was part of an original home and community pilot project. Information from their experience and relevant information was provided to other communities as a sample.

By the end of 2001/02, communities were able to keep people at home, do dressing changes, and provide services to residents requiring home care.

Training

While home care worker training standards vary between Regions, in the Atlantic Region they varied considerably within the Region. In other words, some jurisdictions require a higher standard of training than other jurisdictions. Additional training challenges included the lack of financial incentive to attend training because other financial assistance was correspondingly eliminated. While some trained workers stayed within their community, some went to work in other non-First Nation communities.

According to program tracking data, the number of personal care workers in communities was 63 prior to the FNIHCC Program. According to training plans, the number of positions would increase to 116 through funding. For home care LPNs, these figures would increase from zero to 14 while the number of home care RNs would increase from 2 to 29.

The Canadian Red Cross and St. John's ambulance provided training directly to many of the larger communities in the Region and, where possible, workers from smaller communities came to participate as well.

Partnerships

Following are examples of partnerships fostered during the first two years of the program.

Provincial

- The provinces and individual hospitals saw the opportunity to send people home earlier through the work of the FNIHCC Program. Communications improved with these facilities as work continued on enhancing this. In New Brunswick, some basic home care services were already being provided when patients were discharged, enabling communities to focus on augmenting services already provided by the province.
- Regional Health Authorities provided physiotherapy and foot care services in some locations. They contracted with local VON to provide services as needed, such as when there is not a full time nurse in a small community.

Education and Training

- Partnerships were developed with regional colleges and agencies that provide home support services training to make training more culturally applicable.

Program Linkages

Across the country, Regions linked with other federal agencies and programs, where possible. In Atlantic Region, this included:

INAC

- Communities linked with the adult care program funded through INAC to prevent duplication of services. A few communities have brought the programs in together.

HRDC

- Training dollars were accessed by communities as applicable.

Within Health Canada

- Communications and human resources linkages were made with Community Health and with the ADI. The NIHB program also played a key role in the identification and supply of medical supplies and equipment.

Resources Developed/Distributed

The Atlantic Region distributed to all communities the planning resource kit developed by the National office. In addition, samples of home care policies, a template manual by St. Elizabeth and a video were distributed. A Regional newsletter was produced semi-annually and distributed to communities.

Northern Secretariat - Territories

About the Northern Secretariat

The Northern Secretariat was created in the fall of 1998 to provide a coordinated, cohesive and equitable approach to First Nations and Inuit Health Branch (FNIHB) program delivery issues for First Nations and Inuit living in Yukon, the Northwest Territories (NWT) and Nunavut. The Northern Secretariat was also the departmental lead in assisting the Government of Nunavut establish their Department of Health & Social Services. In the fall of 2000, the Northern Secretariat was also charged with the additional responsibility of becoming the single focus for Health Canada's health promotion and illness prevention programs and other interactions with territorial governments and territorial stakeholders in a partnership relationship.

Mandate

The Northern Secretariat will support a new "single window" approach in facilitating optimum delivery of federal health programs and services in the territories in partnership with territorial governments, First Nations, Inuit and other territorial stakeholders to improve the health status of territorial residents and strengthen their capacity to deliver a broad range of health promotion and illness prevention programs.

The main responsibilities of the Northern Secretariat are to:

- manage the implementation and delivery of Health Canada's community-based health promotion and illness prevention programs in the territories;
- integrate and streamline Health Canada's health promotion and illness prevention programs planning, management and implementation;
- manage the delivery of Non-Insured Health Benefits in all three territories;

- represent, advocate, advise on, and coordinate matters relating to Health Canada's involvement and role in the territories;
- participate in the negotiation and implementation of self-government agreements in the territories; and
- maintain and strengthen partnerships with territorial governments, First Nations, Inuit and other stakeholders in the territories.

The Northern Secretariat also provides additional support, which includes:

- assuming the lead in policy development regarding health programs development and implementation in the territories;
- participation on Inter/Intra departmental committees on issues which affect health programs and services in the territories;
- developing a strategically coordinated approach to the development, adaptation and implementation of health promotion and illness prevention programs and services in the territories; and
- a focal point for all of Health Canada's activities in the territories.

Nunavut Profile

Population	21,144
Average Population per Community	783
Number of Communities Eligible for Funding	27
Number of Communities Funded	25
% of Needs Assessments Completed	100%
% of Communities with Submitted Plans	100%
% of Communities in Planning Implementation	100%
% of Communities with Access to Service Delivery	93%

2001/02

In Nunavut, a "Getting Started" Home and Community Conference was held in Rankin Inlet March 24 to 27, 2001.

According to program tracking data, the number of personal care workers in Nunavut would increase from 102 prior to the program to 166 according to training plans. The number of home care RNs would increase from 5 to 20.

Northwest Territories Profile

Population	15,376
Average Population per Community	466
Number of Communities Eligible for Funding	33
Number of Communities Funded	33
% of Needs Assessments Completed	100%
% of Communities with Submitted Plans	100%
% of Communities in Planning Implementation	100%
% of Communities with Access to Service Delivery	100%

2001/02

The 33 communities in the NWT represent a combination of First Nations and Inuit communities. While there are more communities in the NWT than either Nunavut or the Yukon, the average community size, at less than 500, is smaller than the average in the other two territories.

The Inuvialuit Regional Corporation developed posters to raise awareness of home and community care. The Inuvik Region submitted training plan for five days training session for foot care but capital deferred until next fiscal year. NWT sits on the HCC Regional Steering Committee. Figures were not available on NWT training plans for the program.

Yukon Profile

Population	7,558
Average Population per Community	540
Number of Communities Eligible for Funding	14
Number of Communities Funded	14
% of Needs Assessments Completed	36%
% of Communities with Submitted Plans	--
% of Communities in Planning Implementation	--
% of Communities with Access to Service Delivery	7%

2001/02

Approximately half of the 14 First Nations in the Yukon have a population under 500 and only one community, Kwanlin Dun, has a population over 1,000. Many communities are isolated. Despite capacity obstacles, over one-third of communities managed to complete needs assessments during this period and one community was in service delivery by the end of 2001/02.

According to program tracking data, there were no personal care workers or home care LPNs reported in communities prior to program funding. Training plans indicate that the number of personal care workers would increase to nine and the number of LPNs to four through program funding. There was one home care RN prior to training and no increases were planned.

CHALLENGES

Establishing the First Nations and Inuit Home and Community Care Program continued to be a challenge during these two years, and many of these challenges were in place prior to the announcement of the program. Despite these challenges, significant progress continued to be made in ensuring that the home and community care needs of First Nations and Inuit were addressed.

Partnership/Collaboration

Historically, First Nations and Inuit have not been actively involved in the early stages of accessing funding for new initiatives. For the FNIHCC Program, First Nations and Inuit were involved in providing input into the Treasury Board Submission. In addition, National direction provided that this new initiative was to be planned and implemented in partnership and collaboration with First Nations and Inuit. For this reason, a National Steering Committee was established with equal representation from both government and First Nations and Inuit.

There was an expectation that the partnership and collaborative activities would be carried out at the Regional/Territorial levels as well. In many Regions/Territories, this created some challenges as there had been working relationships that had been developed and there were historical differences in how programs should be delivered.

Developing linkages with other programs and departments was also a challenge on a National, Regional, and Local level. While some linkages have been relatively smooth, other programs were more challenging to integrate due to conflicting mandates, priorities, or opportunities for collaboration. That said, efforts continued in working with these potential partners to identify opportunities for more effective care and more efficient usage of human and financial resources.

Funding for Regional/Tribal Council Coordination

The development of the funding framework for the FNIHCC Program was carried out to ensure that funds would be available to deliver the essential elements of the program. In order to support First Nations and Inuit in the planning process, funding was identified for Regional coordination. In many instances, the funds provided for coordination activities could not adequately cover the coordination that was required. Many Regions used additional internal and program resources to provide additional coordination services. It has been made very clear by many Tribal Councils that they require coordination funding as well as they are

expected to provide advice and guidance to their member communities. As the program gets further into program delivery, there will also be a requirement for second and third level services as well as nursing supervision. It is expected that some of the components in the Needs Based Strategy will begin the process of fully documenting the Regional and Tribal Coordination services (third and second level services).

In many Regions, a significant number of communities are isolated and many accessible only in summer months or via air. As such, travel costs are extremely high.

Training and Capital Funding

While funding for both 2000/01 and 2001/02 included allocations for training and capital spending, the need for such funding was so acute in most Regions that significant gaps remained. This included equipment, as well as permanent assets such as accommodations for health workers and office and storage facilities. Future funding for the program does not allocate money specifically for these two areas and will require Regions to apportion money using total Regional funding.

Staffing

As mentioned, staffing at the Regional level varied significantly across the country. In some Regions, there was only one person dedicated to coordinating the program efforts while other Regions provided resources to employ people to coordinate at the district level and/or additional personnel working either within Health Canada or through partner First Nations/Inuit organizations. Not surprisingly, those with more staff were typically able to work more closely with communities and Tribal Councils to assist in planning, training, capital building, and service delivery implementation efforts.

In some areas, turnover at the community level was a challenge in terms of building capacity and in developing effective communications. Many involved had other jobs and were coordinating planning efforts on a volunteer basis. Those with more coordinating resources at a Regional level were often better equipped to address some of these issues.

Pace vs. Service Delivery

One conundrum facing all involved in the program is balancing the "community pace" aspect of the program with ensuring clients requiring care in community receive services as soon as possible. In an effort to address the latter concern, in 2000/01 the National Steering Committee modified the funding process. In essence, funding was provided to communities in concert with the phase in which they were in for the program. The change in funding was admittedly controversial and was perceived by some as a conflict with the "community paced" aspect of the program. On the positive side, with this change in funding communities did move through the process faster than prior to this change, which enabled community members to begin receiving services more quickly than what otherwise might have been the case.

The original Treasury Board submission outlined that communities were to be in service delivery by the end of 2001/02. While some communities were able to meet this objective, other communities, notably those with lower levels of capacity and/or smaller communities, were more challenged in getting through the phases of the program. It was taking communities longer than anticipated to work through all of the planning process activities and capacity was more limited overall than what had been projected. Other changes during this period included modifications to the contribution agreement template. Incorporating change management theory during this time of transition may have reduced the impact of change on communities and other stakeholders.

Communications

As with most programs of this scope, communications is an ongoing challenge. The challenges include:

Number of Stakeholders

The scope of this program is a complex mix of stakeholders that represent National, Regional and Local interests of First Nations and Inuit health care. Developing communications processes that are both effective and workable is an ongoing challenge when there is such a vast amount of information to share at all levels.

Amount of Communications

With the program requiring input and ongoing communications among National, Regional and community representatives, First Nations and Inuit organizations, other departments and organizations, and health care professionals among others, the communications requirements are vast.

Staffing Issues

Some communities and Regions were better staffed than others were. Those in areas with less support or with high turnover were more challenged in maintaining effective communications with all stakeholders.

Varied Perspectives among Stakeholders toward Communications

There was no consensus on the amount, format, or channels of communications among all stakeholders. All parties were working through a new program that had a condensed time period.

Addressing Communications Challenges

To address these challenges, stakeholders at all levels looked at opportunities. For example, Regional coordinators and Regional partners formalized meetings across Regions during 2001/02. Semi-annual meetings were scheduled as well as monthly teleconferences to share successes and challenges.

Regions developed processes to maximize the human and financial resources they had to coordinate activities and communicate with communities and First Nations and Inuit partners. These included community visits when possible, as well as ongoing telephone calls, email, mail and fax communications.

The National Team worked to develop and implement tools to assist communities and Regions in meeting the reporting requirements for the program. These included the development of the tracking tool, reporting templates, evaluation framework and associated training. Not surprisingly, the reporting requirements were not universally embraced. Workshops and training sessions were organized in all Regions to assist workers in understanding and meeting these requirements.

Training Standards

Training standards for personal care workers vary from Region to Region and, in cases such as the Atlantic Region, they vary considerably within the Region.

Because some areas have significantly higher standards, the challenge was for communities to meet these requirements using the finite funding earmarked for training during the two years.

Inuit Challenges

While challenges exist to varying degrees for all communities involved, it is worth noting the characteristics common to Inuit Regions that affect the planning and implementation of the FNIHCC Program. In the four Inuit Regions of Nunavik, Nunavut, Inuvialuit, and Labrador, there are political, geographical and cultural factors that influence the delivery of health and social services unique to the North.

These challenges include but are not limited to the following:

- Remoteness and isolation
- Cost of service delivery
- Availability and access to appropriate health care services
- Access to health care providers
- Socio-cultural considerations (e.g. many Inuit are unilingual Inuktitut speakers).

While these challenges are certainly not limited to Inuit communities, they help exemplify that culture, geography, size, resources, and access to existing services heavily influence the home and community care capacity of communities.

About The Inuit Regions

The Canadian Arctic has four Inuit Regions, each with its own Inuit Association.

Inuvialuit

- Inuvialuit Regional Corporation was established in 1984 and represents the 5,000 Inuit of the western Arctic.

Labrador

- The Labrador Inuit Association was established in 1975 and represents the 5,000 Inuit of Labrador.

Nunavik

- Makivik Corporation was established in 1978 and represents the 9,000 Inuit of Nunavik Region in northern Quebec.

Nunavut

- Nunavut Tunngavik Incorporated was established in 1992 and represents the 21,500 Inuit of Nunavut.

Source: www.itk.ca

A LOOK AHEAD: 2002/03

For 2002/03, stakeholders including First Nations and Inuit partner organizations, communities, Tribal Councils, Regional and National program staff, and health care professionals will continue to work together to enhance service delivery in communities already at this stage. Stakeholders will also work steadfastly with the remaining communities, which represent approximately one-half of the communities in the country, to move into service delivery mode so program services can begin for community members and their families.

While the years 2000/01 and 2001/02 saw significant funding earmarked for training and capital plans, Regions and their First Nations and Inuit partners will now need to look for funding within the Regional allocation, as no specific funding is allocated for these two areas in 2002/03. To date, the program has helped establish facilities, supplies, and equipment, as well as train hundreds of workers, most notably personal care workers. These efforts will need to continue as other communities move into service delivery and as gaps remaining in training and capital requirements are identified.

At the end of 2001/02, just over one-half of the First Nations and Inuit communities funded for the FNIHCC Program had reached service delivery. These communities represented 282,000 First Nations and Inuit people, almost two-thirds of the total target population for the program.

For the remaining communities working toward service delivery, many face challenges such as community size, resources, and isolation. However, most of these communities have already submitted plans and are actively working with program partners to meet these challenge and, ultimately, to provide home and community care services essential for the people in these communities.